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Resource Sharing Conversion i

RUNNING HEAD: Conversion of Resource Sharing Agreements

U.S. Army - Baylor University

Graduate Program in Healthcare Administration

A Business Case Analysis of the Conversion of Resource  
Sharing Agreement Workload at Joel Health Clinic

A Graduate Management Project Submitted to the Program  
Director in Candidacy for the Degree of Master's in Health  
Administration

March 30, 2004

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Abstract

The Joel Resource Sharing Clinic at Womack Army Medical Center will dissolve upon implementation of the next generation of TRICARE contracts. Three courses of action were identified to accommodate the workload performed under the current contract: two in which the health care is produced by hiring or contracting personnel to see the beneficiaries at Womack, and one in which the care is purchased in the contractor's network. A business case analysis was conducted on each course of action, and non-financial considerations were also identified. The financial analysis discovered an increase in Womack's three-year purchased network care costs of \$12.7 to \$15.3 million should Womack enroll the Joel Resource Sharing beneficiaries (beneficiaries are currently enrolled with the contractor). The study recommends that the beneficiaries remain enrolled to the contractor and reassigned to a primary care manager in the local community.

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A Business Case Analysis of the Resource Sharing Agreement  
Workload at Joel Health Clinic

1. Introduction

Under the next generation of TRICARE contracts, the Womack Army Medical Center (WAMC) must convert its resource sharing agreements (RSA) to provide services currently covered under the RSAs. The new TRICARE contracts do not cover the resource sharing contracts/ resource support agreements as a means to balance direct healthcare costs with network care expenditures in a business case format (Donahoo, 2003). The Joel Health Clinic, one of WAMC's three stand-alone outpatient clinics, includes a RSA clinic whose 6,000 patients (enrolled to the managed care support contractor) are provided primary, specialty and inpatient care by WAMC at a cost of \$9.4 million annually, with \$3.2 million of the care provided by the Joel RSA providers (Maloy, 2003). In turn, the managed care support contractor (MCSC) pays a subcontractor who in turn pays the salaries of the providers and support staff working in the clinic. The approach used by WAMC to redirect this workload will impact the medical center's budget, and the access and the quality of care for those 6,000 beneficiaries covered

currently seen under the resource sharing agreement process.

*Conditions that prompted the study*

*The TRICARE Program*

During the cold war, the Military Health System (MHS) provided health care to its beneficiaries exclusively through its Military Treatment Facilities (MTF's), or through CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), a fee-for-service type of program for non-active duty beneficiaries not located within a reasonable proximity to a MTF. Due to a tight economy, runaway healthcare costs, and poor patient satisfaction with the MHS, the Department of Defense (DoD) began exploring ways to implement a managed care type of system for the MHS (Eden, 2002). The DoD conducted pilot programs that were precursors to--and eventually became--the TRICARE program: Gateway to Care, the CHAMPUS Reform Initiative, Primus Clinics, Delaware Valley Health System, and finally the TRICARE demo in the Tidewater region (Eden, 2002). Womack Army Medical Center first experienced Managed Care as a participant in the Gateway to Care demonstration in the early 1990's (Maloy, 2003).

The Department of Defense (DoD) implemented the TRICARE program in 1993 as a means of delivering adequate healthcare benefits to the DoD beneficiary population (McGee & Hudak, 1995). The program was modeled after the managed care organizations that were gaining prevalence in the civilian health care arena in the early 1990's (Pacchiana, 1997). The program offered three options for beneficiaries: TRICARE Prime--enrollment in an health maintenance organization (HMO) type of benefit revolving around the MHS's military treatment facilities (MTFs), TRICARE Extra--a preferred provider network which did not require enrollment, and TRICARE Standard--benefits identical to the old CHAMPUS program, including deductibles and cost sharing. MHS eligibility provided a wide-range of covered benefits, including the vast majority of medical costs, mental health, prescription drugs, a dental plan, and some home health services. The plan with the lowest out-of-pocket cost was and continues to be TRICARE Prime. Depending on the capacity of the MTF, patients were enrolled in TRICARE Prime at the MTF or to a MCSC civilian network provider. The program divided the continental United States into 11 different regions (with lead agents) for execution of the TRICARE contracts.

The DoD staged the implementation of the TRICARE program over three and a half years, starting with region 11 in 1995 and finishing regions 1 and 2 in June 1998 (Boham, 2000). While the benefits were standard across the different regions, the contracts themselves were not. The level and amount of services provided by the contractor varied from region to region, and even from MTF to MTF. Some contractors provided network services, MTF appointing services, case management, referral management, and discharge planning, while others provided a lesser combination of these services. Some arrangements between the MTF and contractor produced resource sharing and resource support agreements of various size and scope.

#### *Resource Sharing Agreements*

Resource Sharing Agreements (RSAs) allowed the MCSC to provide the MTF with resources (providers, support staff, equipment, maintenance, etc.) to allow the MTF to offer more health care access for TRICARE Prime eligible patients. Due to the nature of military medicine with deployments, personnel ceilings, and budget constraints, MTF's often have under-utilized resources such as available space, operating room time, bed space, and support staff (Eden, 2002). RSA's allowed the MCSC to add resources to

these under-utilized MTF resources thus creating productive capacity at the MTF. Providing these resources was beneficial as long as the cost of providing them was less than the anticipated bill resulting from network care. The provision of the agreements allowed the contractor to bid lower on the overall managed care support contract. Therefore, full exploitation of this process was necessary to ensure that the MCSC did not overrun costs, in which the government contractually shared risk (Health Affairs Policy letter 97-014, S. Joseph, 1996).

*Revised Financing and RSA's*

Problems during the initial fielding of the contracts led to revisions in the fielding of contracts in the last three regions. One change implemented was a budgeting system called revised financing in which the MTF was budgeted to pay for care purchased on the network for TRICARE Prime beneficiaries enrolled to the MTF. Each month the contractor sent the MTF a bill for care performed in the network for MTF-enrolled TRICARE Prime patients. The contract also budgeted a set amount of resource sharing agreements each year. Womack Army Medical Center falls within TRICARE Region 2, one of the regions whose contracts

were implemented under revised financing--as well as other changes--known as the TRICARE 2.0 family of contracts.

These arrangements alleviated some of the expense incurred by the government in the first set of contracts, while benefiting the contractor by promising a set amount of RSA workload. Because the contract encouraged such agreements, revised financing led to healthy resource sharing agreements between WAMC and Humana, the MCSC for region 2. A total of 11 resource sharing agreements were developed and implemented at WAMC, including a variety of specialty services and the primary care Resource Sharing Clinic at the Joel Health Clinic (personal communication, L.K. Mota, October 2, 2003). The agreement originally called for the RSA providers to treat mostly MCSC Prime patients, and a small percentage of MTF Prime patients (around 6%). During fiscal year 2002 the Joel RSA Clinic provided 22,628 patient visits (personal communication, L.K. Mota, October 2, 2003).

However, upon execution, the bill produced by the contractor presented problems due to disputed figures produced by the contractor's data systems and the MTF's data systems. Also, a review of the workload for the clinic during fiscal year 2002 showed that the Joel RSA providers

also treated well over 6% MTF TRICARE Prime patients per year, and even 100 active duty visits. Humana billed the government for these visits (excess MTF prime target and military members). So while the RSA benefited both parties, the actualization of the agreement has not been problem free.

#### *Joel Health Clinic*

Joel Health Clinic opened in 1998, consolidating Troop Medical Clinics 21 and 22 (active duty only), and also became open to enrollment of TRICARE Prime eligible beneficiaries, including eligible active duty family members, retirees, and retiree family members. Additionally, the Joel building houses the Joel Dental Clinic, which was part of the original design plan, and the Soldier Readiness Center (SRC), a deployment/ mobilization facility unique to Fort Bragg that processes the high volume of soldiers that deploy from this post. This additional mission places severe space constraints on the leadership's ability to expand the clinical mission in the building, or to fully implement optimization programs with current organic assets.

The Joel Health Clinic operates a family practice clinic, an immunization clinic, a flight medicine clinic, a

physical exams section, an optometry clinic, laboratory, radiology section, and a pharmacy. The building's floor plan encompasses 65,641 sq. ft. as well as two modular buildings nearby to accommodate overflow missions belonging to the SRC. Joel Family Practice Clinic, the primary care vehicle of the Joel Health Clinic, operates with 16 provider full time equivalents (FTE) and 26 exam rooms and offices.

#### *Joel RSA Clinic*

The Joel RSA clinic consists of six exam rooms and four offices, which is about twice as much space per FTE as the Joel Family Practice Clinic. The resource sharing agreement provides the following staff to the Joel Health Clinic: 2 family practitioners, 1 physician's assistant, and 1 nurse practitioner for a total of 3.8 FTE; 6 nursing personnel including 2 registered nurses, 2 licensed practical nurses, and 2 certified nursing assistants; a pharmacist and a pharmacy technician, 2 radiology technicians, and 4 administrative personnel.

WAMC provides almost all of the other required support including all of the overhead costs of facilities and utilities, information management/ information technology support, telephone services, appointing, and supplies.



Humana performs procedure coding (outpatient) for the RSA providers. Although the clinic attempts to provide uniformity in services to patients in both clinics (Joel Family Practice and Joel RSA), there are some minor procedural differences, particularly in appointing referrals outside of the WAMC system. Still, WAMC treated Joel RSA patients for specialty and inpatient care at a cost of about \$6.2 million in fiscal year 2002 (Maloy, 2003). The contracts are supposed to encourage the MTF Commander to optimize the capabilities of the MTF. The bill for the contracted personnel provided by the MCSC probably runs between \$1.4 million and \$1.6 million, far less than the cost of the care provided in WAMC to those MCSC Prime beneficiaries (Beard, 2003).

During a personal interview, Ms. Laura Mota, the Joel Health Clinic administrator, noted that there are severe space limitations in the family practice clinic, and demand has existed and still exists from retirees wishing to enroll at WAMC through the Joel Health Clinic. According to the WAMC TNEX Market Analysis (2003), the number of total eligible persons within WAMC's catchment area is 162,022, with 124,721 enrolled to one of the four primary care clinics in the WAMC health care system. Additionally,

capacity exists for only 24% of the retirees and 22% of their family members, or a total of 7,729 MTF Prime enrollment slots available for 40,952 retirees and retiree family members in the catchment area. The enrollment of 6,000 patients (mostly retirees and retiree family members who could be seen at the MTF for most of their healthcare needs) at Joel RSA clinic partially addresses the retiree population's demand for health care services. The military retiree community's voice is politically strong and was critical of the TRICARE program during its implementation. The RSA clinic has helped alleviate some of this strife at Fort Bragg.

In addition to the retirees, approximately 1,000 of the beneficiaries are dependents of active duty service members, many who are currently serving overseas in the Global War on Terrorism (L. Mota, personal communication, February 3, 2004). Keeping this group of patients in-house corresponds with our strategic focus, and next to active duty care, care of active duty family members is our top priority. To make matters more complicated, through my inquiries I found that anecdotally many enrollees were not informed of their enrollment to the contractor, and still believe they are enrolled to the MTF. Because they are seen

in a MTF, they assume that they are MTF Prime. These patients may be confused, and probably upset, if the MTF changes their enrollment to a primary care manager in the surrounding community once the resource sharing agreement ends on July 1, 2004.

Meanwhile, the Joel RSA clinic was offering some benefits to the command and the MCSC. Under the RSA, the MTF commander maintained operational control of the care provided to the beneficiaries in-house using assets paid for by the MCSC. Additionally, the ancillary and support staffs were utilized in the Joel Health Clinic as seen fit by the clinic leadership, not solely in support of the Joel RSA providers. The RSA providers used MTF logistical resources, but the MCSC workload counted as if the visits occurred outside the MTF on the network. Also, the Joel RSA incurred additional costs for the government beyond the bid price because (1) they consumed supply and facility dollars from the MTF, and (2) the MTF received a bill if over 6% of the patients seen by the RSA providers were non-MCSC prime or active duty. Additionally the fee-for-service conditions under which the Joel RSA Clinic providers operate led to the possible churning of patients via an unbalanced patient mixes, multiple appointments for minor issues, and the

reluctance of telephonic follow up (an unpaid service) (personal communication, L. Mota, 2003).

*Link to Business Plan and Strategic Goals*

Due to issues mentioned above, the TRICARE next generation of contracts are designed to discourage resource sharing agreements, and facilitate more focused healthcare economic decision-making in the MTF. The MTF commanders have greater control (and accountability) in managing their health care markets, while at the same time contractor penalties are reduced with more contractor incentives for excellent performance (Eden, 2002). The WAMC executive staff with resource manager advisory must decide whether or not to enroll to the MTF the 6,000 Joel RSA beneficiaries. The MTF must decide whether or not to enroll those 6,000 MCSC Prime beneficiaries and take fiscal responsibility for the sum total of their care, including their network inpatient and outpatient care. This arrangement may not provide an incentive to maximize the utilization of MTF resources if the revised financing bill exceeds the cost savings under the project. Regardless, make or buy, the conversion of the RSAs at Joel Health Clinic should produce a cost savings for the MTF and contribute to the overall goals of TNEX:

- Deliver high quality health care services at the maximum value, making best possible use of the existing direct medical care system and incorporating best commercial practices whenever practicable.
- Support Services' readiness and peacetime mission requirements.
- Maintain beneficiary satisfaction at the highest possible level.
- Achieve continuous measurable improvements in the health status of our beneficiaries.
- Develop a transition plan that minimizes disruptions to beneficiaries. (Randolph, 2001).

The conversion of the Joel RSA workload should also support the WAMC strategic plan. This initiative should support Goal 5 of the WAMC Strategic Plan (2001): "Expand clinical services, recapture care, and expand educational programs to better serve our customers to enhance the health and wellness of our customers (p. 10)." This goal includes Sub-goal 5.1: "Determine priority of workload recapture initiatives and develop plan to recapture workload based on priority. Evaluate workload deferral to the network (p. 10)." The project should provide the

information necessary to choose the best means of converting this workload from the Joel RSA Clinic. Additionally, in taking care of a large portion of the retiree population, this decision must also contribute to Goal 3: "Improve the health of the population and the Fort Bragg community (p. 3)"; and Goal 7: "Streamline access to and continuity of care within the Womack Healthcare System (p. 13)."

A solid analysis for the conversion of the RSA workload at Joel Health Clinic is necessary to support the above goals of the TRICARE next generation of contracts, the Army Medical Department (AMEDD) balanced scorecard (BSC) and the overall strategic plan of WAMC. This plan must be based on a strong financial analysis that provides a firm foundation for the proposed business case. Additionally, the analysis must consider those factors apart from cost: beneficiary satisfaction, patient access, market impact, and impact on the infrastructure and services of the entire medical center.

#### *Continued Funding of the Joel RSA Workload*

No additional appropriated funding is available nor has been set aside to cover the current resource sharing costs. Several possible funding solutions/ alternatives

were presented at the TRICARE Senior Leadership conference in November 2003. First, the MTF could seek funding for RSAs it wishes to retain through the service's venture capital program. Alternatively, MTFs can fund RSAs through the hospital's normal operating budget, if the commander chooses to fund the RSA workload over another budgeted area. Finally, the TRICARE Management Activity (TMA) Chief Financial Officer, Mr. Ford, and Dr. Winkenwerder, the Director of TMA, stated that they would make a request to Congress to "un-fence" the money associated with resource sharing agreements, but the projects would face a business case process similar to the venture capital program (Rubin, 2003). The current approval process for venture capital projects requires scrutiny of the project at least five levels of review prior to approval by the Army Surgeon General. The venture capital process is not rapidly executable or as flexible as the original RSA process. Additionally, the details and start date of the aforementioned process is unknown.

The US Army Medical Command (MEDCOM) Venture Capital Program provides WAMC with the best chance of funding the additional providers at Joel Health Clinic. The project qualifies as a venture capital project because it may

recapture care from the contractor for both primary and specialty care, and also avoids inpatient care leakage to the network. The venture capital approach also offers advantages over other approaches of funding. First, WAMC's budget cannot absorb the total cost of this project, given the current budget constraints indirectly placed on the MHS due to the Global War on Terrorism (GWOT) and Homeland Security missions. This year WAMC will face a budget decrement of \$14 million, based on current budgeting figures. Additionally, current MTF Prime enrollment is already at 101% capacity, and not open to further enrollment of MCSC Prime patients without the addition of more primary care providers and support staff. In the future, the project could be funded with the resource sharing dollars, if the money is unfenced and the project meets the scrutiny of the approval process emplaced by MEDCOM and TMA.

Given that the most suitable funding mechanism for the project is through the MEDCOM Venture Capital Program, I focused my business case analysis (BCA) according to the guidelines and templates outlined for venture capital projects by the MEDCOM Program Analysis & Evaluation Office. Utilizing the MEDCOM Venture Capital Program, the



project must show a positive ROI and sustain itself within 36 months of the start date, or must correct a severe clinical deficiency which could cause the organization adverse outcomes resulting in claims against the government. However, as of this printing, the Venture Capital Program is on hold pending funding from TMA.

*Statement of the Problem*

How can Womack Army Medical Center best convert the workload that is currently covered by the Joel Primary Care resource sharing agreement, which is scheduled to contractually expire under the new TRICARE contracts: transfer enrollment to MTF employed providers (make 1); transfer enrollment to MTF contracted providers (make 2), or continue enrollment to the MCSC with a local primary care manager (buy)?

*Literature Review*

According to Finkler and Ward (1999) when faced with a non-routine decision, such as the one presented in this project, managers must address three areas: identifying a wide range of alternatives, define only the costs relative to the decision, and identify non-financial benefits or issues related to the decision.

One of the non-financial implications in this study is the conversion's impact on patient satisfaction. A recent study of inpatient patient satisfaction by Wolosin (2003) showed that the top three satisfaction items were skill of the physician, friendliness/ courtesy of the nurses, and friendliness/ courtesy of the physician. Healthcare consumers place high importance on these personal interactions and relationships. Having direct influence over the atmosphere and policies that relate to the satisfaction of our beneficiaries (rather than having the patients seen on the network) is desirable to the command.

Likewise, the benefits of expanding capacity to accommodate demand of patients desiring enrollment are presented in the Institute of Medicine's 2000 report: *Managed care systems and emerging infections: opportunities for strengthening surveillance, research, and prevention.* The report presented the opportunities for collaborations between population health entities and managed care organizations (MCOs) to enhance the health of the population, along with maintaining costs. MCOs like the MHS are able to use powerful information systems and large patient populations to promote research, create clinical practice guidelines, monitor disease and infections, and

provide outreach programs to beneficiaries (Davis, 2000). Therefore, managing the care for as many of our beneficiaries as possible (for which we have capacity) should be our goal. The AMEDD Balanced Score Card identifies the goal on the current strategy map: Optimize Total (MCSC and Direct) system efficiency (F-3) (AMEDD Strategy Map, October 15, 2003).

Will the end of the RSA change our capacity? We need to consider the productivity of the providers as salaried employees vs. fee-for-service. Van Amerongen (2002) states that any compensation method should align the incentives of the worker with goals of the organization. A fee-for-service arrangement with health care providers leads to a higher volume of patients being seen, due to the physicians "unique ability to increase volume even as the cost per unit decreases (p.187)." Additionally, Sorenson and Grytten (2002) found a range of decrease in productivity with salaried vs. fee-for-service providers of 20% to 40%. They attributed this discrepancy to the shorter hours and lifestyle demands of salaried employees, as well as the financial incentives of fee-for-service providers to see as much volume as possible. The financial analysis of this case may give indications as to whether or not this exists

at Joel RSA Clinic. A decrease in the supply of medical care must be considered in the financial scenario.

Currently, the 16.1 provider FTE's at the Joel Family Practice Clinic have 17,961 patients enrolled to them for a current panel size of 1,115 per FTE. A staffing model project conducted by Pacchiana (1997) recommended a panel size of 1,318 for the primary care providers at Joel. The Joel RSA providers under the current fee-for-service arrangement have panels of about 1,580 per FTE. If the Joel RSA providers assume the same size panels of the Joel Family Practice providers, or even the recommended panel size, this will result in a shortage of health care.

Additionally, a look at the care received in other parts of WAMC by the Joel RSA patients might indicate that the Joel RSA providers are overwhelmed by their panel size. The Joel MCSC Prime patients used the Emergency Department, the Acute Minor Illness Clinic, and the Joel Family Practice clinic at a cost of approximately \$890,000 in FY02 and even utilized \$17,500 worth of primary care on the network (Maloy, 2003).

In addition to panel size, the leadership should consider the advantages and disadvantages of employing personnel and contracting them, particularly in the health

care environment, where much of our strength relies upon human resources. When an organization directly employs its personnel, the organization has maximum control of the human resources function. Some of the outcomes associated with human resources include better recruitment and retention, more tangible employee stakes in the organization, higher job satisfaction, and motivation (Fottler, 2002). Conversely, when an employer procures personnel from an agency, the employer defers much of the human resources control to the contract agency. In the environment of the TRICARE next generation of contracts, the MTF commander probably wants more control over these human resource assets in order to more effectively manage his health care assets and ultimately bring care back into the direct care system. Still another factor to consider in contract vs. hiring is the availability of medical human resources in our area. According to the Dartmouth Atlas of Health Care (1999), our location in Eastern North Carolina is about at the national average for RNs per capita, but only at 75 to 90% of the national average for active physicians. These ratios also often vary across specialty lines. Due to these health human resource considerations, I

have distinguished the two "make" courses of action in the problem statement.

### *Purpose*

The purpose of the study was to provide the leadership at Womack Army Medical Center with financially based projections on the cost and effectiveness of the different options associated with the imminent elimination of the Joel RSA. Additionally, the project identified and assessed the qualitative aspects of each scenario. The management of this workload is one of the many responsibilities of the MTF under TNEX. According to the AMEDD Market Management Plan of Instruction (2003), "under the TNEX family of managed health care contracts, military treatment facilities will assume a variety of operational and strategic responsibilities previously held by the managed care support contractors or other entities such as lead agents (p.1)."

The large number of beneficiaries currently relying on the services of RSA providers stresses the importance of this conversion to WAMC. The primary concern is that the beneficiaries that rely on those services continue to receive quality, timely care promised by the TRICARE Prime

benefit option. Additionally, the MTF needs to consider the method of executing the next generation of TRICARE contract that allows for the best value of utilizing the taxpayer's money and scarce resources in the Defense Health Program. The human factor is also important in this decision. Many retirees now seen at the Joel RSA clinic believe they are enrolled to the MTF, not the MCSC. WAMC is the ostensible agent-- in the patient's eyes the providers in the Joel RSA Clinic work for WAMC. The study was also directed under the AMEDD TNEX plan of instruction (2003), which states that the business plan for market management will include resource sharing make vs. buy decisions.

## 2. Methods and Procedures

This project examined the conversion of the Joel RSA clinic workload using the model outlined in the Business Case Analysis Guide by Marty J. Schmidt (2002). Schmidt (2002) presents the business case in five parts: introduction; methods and assumptions; business impacts; sensitivities, risks, and contingencies; and recommendations and conclusions.

### *Introduction*

The case introduction consists primarily of those areas already covered in the project proposal--the

conditions that prompted the study, the problem statement, and the purpose--as well as a deliberate statement of the subject, a disclaimer, and a link to the strategic business goals in the business plan. In Schmidt's (2002) model, "A business case focuses on what follows from a single action, or decision alternative, while the business plan anticipates sales, expenses, margins, and profits for an organization" (p. 12). In the federal health care sector the business plan revolves around cost, cost avoidance, budget, network recapture, and third party collections. Additionally, the introduction should include any other important information that helps describe the subject and its surrounding conditions.

#### *Methods and assumptions*

This section identified the boundaries of the case, to include the costs, benefits, and time period involved (Schmidt, 2001). This part of the case defined metrics to be used in the decision making process, as well as developed scenarios. Also, the major assumptions involved in the BCA are discussed in this section. The third part of the BCA described the methods used in the BCA as well as the assumptions made by the researcher. The methods used included the tools outlined below.



*Business Impacts: Strategic management tools*

A key component of identifying the assumptions in the case involves the use of strategic tools to describe the health care environment. In addition to the time-tested and simple SWOT (strengths, weaknesses, opportunities, and threats) analysis, other tools exist for analyzing the health care environment such as trend/ issue identification and evaluation. The SWOT analysis attached to the last strategic plan (fiscal year 2001) was evaluated for the various strategic issues that might be affected by or changed by this RSA conversion. A trend/ issue identification and evaluation provided "a starting point for speculating on the direction and rate of change for identified trends" (Ginter, Swayne, and Duncan, 2002, p. 77). From this point the RSA workload was evaluated from its position on the value chain as a point-of-service function, and its relation to other service delivery functions, as well as the organization's strategic resources (Ginter et al., 2002).

*Business Impacts: Financial Analysis*

The cost and benefit figures are presented as full value costs, where costs are presented for each course of action, as opposed to only providing incremental changes

between courses of action. This approach is useful when there is no "business as usual" course of action (Schmidt, 2002). Raw visit data are limited as much as possible since relative value units (RVUs) and relative weighted procedures (RWPs) are available for use. RVUs (outpatient) and RWPs (inpatient) generally establish a standard unit of care at 1 (i.e. adult primary care visit) and then a value is given to other procedures in that service based on the cost of supplies, equipment, time, and labor relative to the standard unit. Additionally, full cost data was available, and was useful in projecting the true cost of each course of action.

Using fiscal year 2002 data and adjusting for medical inflation, I made a probabilistic estimate on the costs for each course of action (COA): transfer enrollment to MTF employed providers (Make 1); transfer enrollment to MTF contracted providers (Make 2), or maintain enrollment to the MCSC with a local network primary care manager (Buy). The probabilistic estimate was generated using the MEDCOM BCA 5.2 template for Microsoft Excel. The MEDCOM BCA 5.2 template provided a linked, easy-to-understand format in which the variables were entered, and the financial ratios and summary were then calculated by the spreadsheet. The

MEDCOM Program Analysis and Evaluation Office uses this tool to evaluate venture capital projects. The tool provided a format that incorporated the costs normally associated with a project like construction, capital equipment, personnel, and base operations, as well as those that might be overlooked such as transportation, travel, changes in third party collections, and additional supplies. However, because of the nature of this project, many of these fields were unchanged, zero, or not applicable. The template also incorporated financial tools such as net present value and savings-to-investment ratios.

Net present value is defined by Gapinski (2001) as "a profitability measure that uses the discounted cash flow (DCF) techniques (p.411)" that finds the time 0 value of all the inflows and outflows, discounted at the project cost of capital. The savings-to-investment ratio is the MHS's equivalent of a Return on Investment (ROI) Ratio. Finkler and Ward (1999) define the ROI ratio as "a ratio that divides the amount of profit by the amount of the investment (p. 430)." The MTF can use the ratio to better show the percentage of funds recaptured to costs of the course of action.

The probabilistic estimate provided values for the different courses of action at the "most likely" level, an extrapolation of fiscal year 2002 data. If the values showed a positive ROI for a course of action's most likely scenario, the best case and worst case scenarios would have been determined using the sensitivity analysis function in Microsoft Excel, analyzing the areas of risk that follow in the next section. However, for this study, there were no positive cost savings ROIs.

*Sensitivities, Risks, and Contingencies*

The general model that was used in this business case analysis is displayed in figure 1. The decision on the conversion of the workload at the Joel Health Clinic was supported by three courses of action each with a best case, worst case, and most likely scenario.

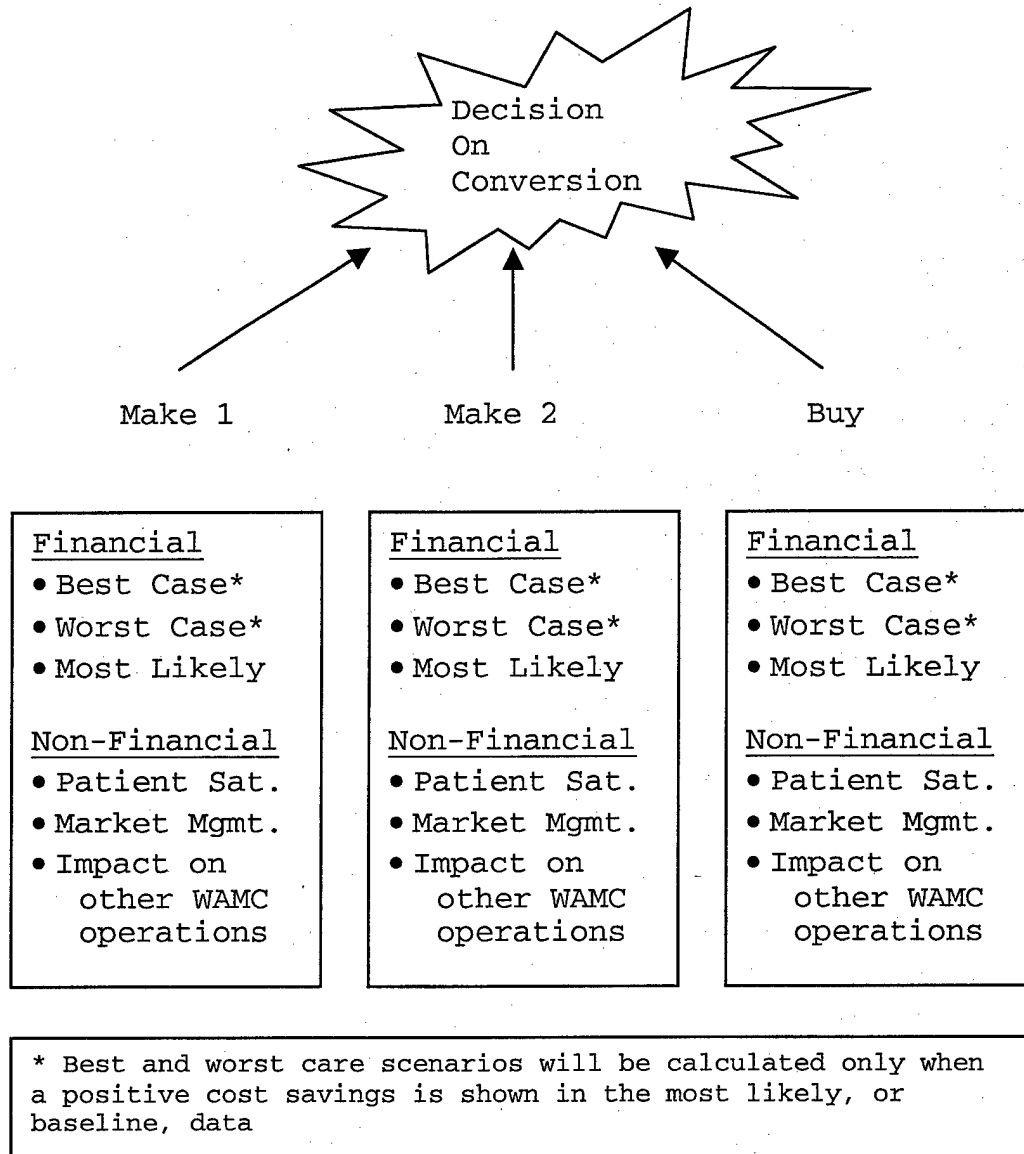


Figure 1. Model for business case regarding the conversion of the RSA workload at the Joel Health Clinic

### *Recommendations and Conclusions*

The recommendations and conclusions section organized the results based on the objectives of the MTF (Schmidt, 2002). This section includes both financial and non-financial results for each course of action. The recommendation section also alerts the command of particular issues in the organization that might influence these results. Finally areas for additional research are identified in the conclusion section.

### *Data Sources*

Baseline data was collected on the Joel RSA Clinic using the data systems available at WAMC. Data was pulled from M2, the MHS Management Analysis and Reporting Tool. M2 is the tool used to access information pulled from the MHS data repository, which is fed by the following systems: the Defense Enrollment Eligibility Reporting System (DEERS), Expense Assignment System, Version 4 (EAS-IV) cost accounting system, the Composite Health Care System (CHCS) for clinical encounters (CHCS), the Managed Care Support Contractors systems, and the Ambulatory Data Module (ADM), which codes diagnosis and treatment data (Bowman, 2002).

*Ethical Considerations*

This study did not require review by the WAMC Institutional Review Board, due to its primarily financial nature. No individual names, identification numbers, or clinical conditions are detailed in the study.

3. Results

*Results Summary*

The primary objective of this project was to determine whether or not the hospital should make or buy the health care necessary to handle the workload of these 6,000 enrollees that we are statutorily bound to provide as a defense health program. This process involved carving out only those factors affected by the RSA conversion and revised financing, ignoring sunk costs. Conversely, each relevant cost had to be identified and considered.

The Make 1 and Make 2 options in the BCA are very costly due to the revised financing bill connected to those two options. One major factor discovered during the initial BCA process was the large amount of money consumed in the network by the Joel RSA enrollees. If the 6,000 Joel RSA enrollees are enrolled as MTF Prime, the MTF will inherit the approximately \$7.5 million (adjusted for inflation, based on FY02 data) annual revised financing for those

patients' network care. This additional cost far outweighs any financial benefit from producing this health care by either hiring or contracting the individuals now performing primary care under the RSA. The focus of the results, and indeed of the analysis itself, immediately shifted from the question of "contract vs. hire" to "in-house vs. network". The contract vs. hire becomes largely irrelevant, because both the options add the overwhelming costs of the revised financing bill for those patients.

Over the three-year life of a venture capital project, the MTF would lose \$15.2 million if it hired the providers necessary to convert the Joel RSA patients from MCSC Prime to MTF Prime. If WAMC loses inpatient admissions due to the 6,000 patients returning to the network, the medical center has the potential to lose \$8.5 million over three years. In either case, the MTF would or could lose money. This problem is unique to RSA's in which MCSC Prime are seen at the military facilities. Because no cost savings exist, calculations of a cost savings ratio and a net present value become impossible. Under the current operating rules and regulations, any method of providing care to these enrollees will result in higher costs to the MHS. The



contractor also loses, because less care is pushed into the facility, and their network costs increase.

#### *Methods and Assumptions*

Some major assumptions were already identified in the project proposal. The first assumption was that personnel are readily available to fill the positions that will be vacated when the contract transition occurs. The second assumption was that the productivity rates for the providers would decrease if the fee-for-service incentive were eliminated.

In the analysis the following assumptions are made and defended:

1. No change will occur in outpatient provider productivity if the physicians are contracted. The current contract providers will continue to perform at similar levels with their fee-for-service contracts. Sensitivities in productivity change will be conducted if the "make" option shows a cost savings.

2. Provider productivity will decrease 20% if the providers are hired as GS employees, due to lack of FFS incentive. This corresponds with the study by Sorenson and Grytten (2002) showing a difference of 20-40% in the productivity of FFS vs. salaried providers. This decrease

will result in proportionally smaller panel sizes, resulting in a proportionally smaller number of outpatient visits.

3. Current patient utilization patterns will persist after the conversion patients from MSCS Prime to MTF Prime.

4. Current clinical operations will not change, and the conversion of the workload will not result in the need for any physical plant or equipment changes.

5. Inpatient care is subject to a 5% inflation rate.

6. I calculated a 1.62% annual increase rate for reimbursement under the CHAMPUS Maximum Allowable Charge (CMAC) rates. This is the current CMAC increase posted by TMA.

7. Based on values presented at the 2004 TRICARE conference for the prospective payment system of budgeting, \$74 will be the value used for each RVU and \$5,268 for each RWP.

8. All inpatient admissions from the population currently served by Joel RSA Clinic will go to the network if those patients are not enrolled to the MTF. This is both a worst case and most likely scenario. The reasons for this assumption are further explained in the discussion section.

10. Health human resources are available in the Fayetteville area to immediately fill the civilian employee and contract employee positions. Still, since the density of professionals in Fayetteville requires even the local hospitals to compete for employees via special recruitment & retention programs. The decision maker should consider the impact of this assumption, as time constraints grow tighter.

11. Due to the availability of a generous pharmacy benefit in the MTF, most prescriptions will continue to be filled at the MTF, and therefore will not change nor impact this BCA.

12. The impact on the MTF ancillary services will not cause a significant difference in the outcome of this BCA.

13. Finally, I also assume that the Revised Financing processes will remain the same throughout the upcoming set of contracts.

Initial figures were programmed into the MEDCOM BCA Template 5.2 as outlined previously. The template had to be modified in a few areas to accommodate this analysis. First, the template was designed to analyze a project needing start up capital. In the "make" analyses, capital is required to cover personnel costs, but there is no

similar capital requirement in the buy option. In the "buy" option, there are actually negative costs, because the MTF would no longer be purchasing marginal supplies for those patients. Likewise, under the revised financing sheet, I included a negative savings for the two make options. This was needed due to the "inheritance" of the network care bill that would follow enrollment of the patients into the MTF. As stated in the methods section RVUs and RWPs were incorporated into the template as much as possible.

Because the revised finance network costs are almost twice the recapture benefit in the most likely scenarios for options Make 1 and Make 2, no need existed conduct sensitivities on the thresholds of either panel size or productivity. Discovering the revised financing portion of the cost of the "Make" options greatly reduces the need to continue into further detailed analysis of either "Make" courses of action. What must now be considered is whether or not the large price tag of either if the Make options is worth the non-financial benefits of converting the patients to MTF Prime. The financial analysis clearly shows that the conversion of the patients to MTF Prime will definitely cost the facility millions more than the possible potential outpatient and inpatient recapture.

*Financial Results*

The spreadsheet results of course of action Make 1 can be found in Appendix B. The transfer of enrollment of the Joel RSA patients to the MTF will cost the MTF \$15.2 million (net) over the first three years of the contract. This includes any offsetting recapture savings.

The spreadsheet results of course of action Make 2 can be found in Appendix C. Under this course of action the enrollment of the Joel RSA patients to the MTF would cost the MTF \$12.7 million over the first three years of the contract. This also includes any offsetting recapture savings.

The spreadsheet results of course of action Buy can be found in Appendix D. Purchasing the health care on the network could potentially cost the MTF \$12.5 million in lost inpatient admissions and outpatient visits over the next three years, far more than what is currently spent on the Joel Resource Sharing Agreement. However, the network care bill to convert the 6,000 patients to MTF prime will amount to over \$22.3 million during that same three-year period. In this case, revised financing provides a perverse incentive to keep business out of the medical center: the MTF will actually avoid \$10.6 million (over three years) in

revised financing bills from the contractor by not enrolling these 6,000 patients. This figure includes a deduction of 100% of the potential lost recapture.

### *Non-Financial Impacts*

#### *Patient Satisfaction*

A summary of the advantages and disadvantages of each COA can be found in Appendix E. The impact on patient satisfaction on course of action Make 1 will be negative. Due to the restructuring of panels, a decrease in provider productivity, and ultimately the decrease in capacity will most likely occur with the hiring option, due to the removal of the fee for service incentive that the RSA providers currently enjoy.

In course of action Make 2 the customer satisfaction should remain neutral. This course of action is the closest to a "do nothing option". Make 2 would be the recommended course of action if the MTF did not incur the network costs for those beneficiaries.

Course of action Buy, the network option, has the potential to be a public relations nightmare. Although the patients assigned to the Joel RSA Clinic are, and always have been, MCSC Prime, that fact was never fully advertised to those patients. The patients will most likely perceive

that WAMC is reducing services to retirees and disenrolling active duty family members.

*Market Management*

Make 1 gives the command the most control over the health care delivery to those 6,000 patients, including primary, specialty, and inpatient care. The command also has greater control over human resource management of the direct hire assets.

Make 2 also gives the command the most control over the health care delivery to those 6,000 patients, including primary, specialty, and inpatient care. The primary difference between Make 1 and Make 2 is that the command has less control over the hiring, evaluation, and other human resources functions that will be controlled by the contractor. The MTF commander must still complete missions, regardless of whether or not the contracting firm is able to perform its stated work in the contract.

The "Buy" course of action is the least desirable in managing the health care of our beneficiaries. Even though the MTF has the right of first refusal for inpatient care, this right is difficult to exercise under the current referral management conditions. This arrangement might change with the new contractor; however, it will

undoubtedly take some time for the contractor to produce a robust network referral management system. In the end the contractor might find it less bothersome and cheaper to pay the claims outright than to deal with a network referral management system. The point is, the managing of care on the network is currently very limited, and we don't know what the future holds in this area until we see the contractor's system and processes.

*Impact on Other WAMC Operations*

The impact of the two "Make" courses of action on the MTF would be enormous, mostly due to the high cost of those courses of action. The medical center would have to reduce services in other areas to pay for the large network care bill generated by these 6,000 enrollees.

The "Buy" course of action will affect WAMC operations, but in different ways. This could impact the cost per RVU and RWP of our specialty and inpatient services, if volume decreases in this area. However, the demand for these services already exceeds capacity in many areas, and network leakage from the MTF prime enrollees might be reduced. This area begs further study. From the information gathered during this research, both financially and anecdotally, I highly doubt that we would see a great



reduction in MTF workload by ending care at the Joel RSA Clinic.

## Discussion

### *Relationships to Strategic Plans and Goals*

The intent of this study was to provide the command with the information needed to make a well-informed decision based on an analysis that incorporates the TNEX goals, the AMEDD Balanced Scorecard, and the WAMC Strategic Plan. WAMC is a federal hospital, which makes it different in many ways from a civilian run organization; however, many of the principles are the same: the proposed course of action should not only fit within the budget constraints of the organization, but should also recapture workload, or at the very least prevent the leakage of MTF Prime care into the network, where it will negatively impact our budget.

The base of the AMEDD Strategy Map begins with two resource-based goals: predict and secure levels of funding required, and operate within budget. The business case analysis predicts the levels of finding required and shows that we will probably not be able to operate within budget if we enroll the Joel RSA patients.

One of the goals of TNEX is to "deliver high quality health care services at the maximum value, making best possible use of the existing direct medical care system and incorporating best commercial practices." Does WAMC meet the intent of the TNEX Goals if it chooses not to recapture this care? Under the present rules and regulations, I believe it absolutely does. The decision to enroll the patients cannot be made in vacuum. In our anomalous situation, we would severely limit services to our enrolled patients by taking on the enrollment of the MCSC enrollees. I am presenting a business case that is modeled after commercial venture capital practices. A commercial enterprise would not sign up for a venture that would lose \$12-15 million, when it currently avoids \$8 million in charges.

Still, a major goal of TNEX is to provide a seamless transition with minimal disruption to beneficiaries. The Buy COA clearly falls short of this goal, at least for the 6,000 Joel RSA patients. But the alternative, under funding or cutting other services in the medical center, has the potential to disrupt services for our 120,000 MTF enrollees for whom it has primary responsibility.

In the introduction I mentioned the goals of the WAMC Strategic Plan (2001), and how they should relate to the selected course of action. Goal 5, "Expand clinical services, recapture care, and expand educational programs to better serve our customers to enhance the health and wellness of our customers (p. 10)", is met only indirectly through the Buy COA. While the COA provides no recapture of workload, indirectly the release of resources back into the MTF could help to increase the quality and access to the MTF enrollees. This goal includes Sub-goal 5.1: "Determine priority of workload recapture initiatives and develop plan to recapture workload based on priority. Evaluate workload deferral to the network (p. 10)." Indeed, this recapture initiative has been evaluated and as shown previously would be very costly to the MTF were it to recapture this care. Goal 3 is "Improve the health of the population and the Fort Bragg community (p. 3)." Only time and study will tell if the recommended Buy COA will have positive or negative outcomes for the overall health of the Fort Bragg community. Finally, Goal 7 states that we should "Streamline access to and continuity of care within the Womack Healthcare System (p. 13)." I believe the Buy COA will improve access for the MTF enrollees. I have mentioned

throughout the paper that the fee-for-service RSA providers are more productive than their salaried counterparts. The additional space and support staff afforded to the RSA providers may enhance this difference in productivity. Still, the largest unknown factor in the Buy COA is how well the new contractor will take care of its beneficiaries that we entrust to their care in their network.

#### *Financial Impacts*

The quantitative financial impacts of each course of action are discussed in the results section and outlined in detail in Appendices B-D. Clearly, the bottom-line figure of total cost savings and cost avoidance are the most important parts of the financial analysis. Still, other considerations must factor into the decision. These include the federal nature of Womack Army Medical Center's existence; the probability of a funding or policy change from TMA, MEDCOM, or the North Atlantic Regional Medical Command (NARMC); and the current health care capacity at WAMC.

Due to the federal nature of our facility, local practicing physicians are not privileged in the facility except under highly unusual circumstances (C.G. Burden, personal communication, January 15, 2004). This

relationship, or lack thereof, will not allow us to compete for admissions with local hospitals. Unless the contractor puts a system in place that efficiently utilizes the MTF's right of first refusal, the patients enrolled in the network would likely receive their specialty and inpatient care on the network. The relationships between the local specialty providers and hospitals would dictate this.

The continual change in definitions and procedures related to TNEX and the fluid manner in which the TNEX contracts are being executed make the results of this GMP tenuous. With approximately 4 months until health care delivery, many factors are still unknown regarding the TNEX implementation. As the policies stand, WAMC will inherit a \$22.3 million (three-year total) revised financing bill for the 6,000 patients in the RSA clinic if the MTF enrolls them.

Finally, the hospital is currently at 101% enrollment capacity, and struggles to meet access standards in some specialty services for the current Prime beneficiaries enrolled to the MTF. As stated earlier on the literature review, health care providers have a way of generating demand even as health care supply increases, a phenomenon also known as supplier induced demand. From another

perspective, returning the MCSC Prime patients to the network may help alleviate some of the stress on the current access issues in WAMC and actually prevent some network leakage from our MTF Prime patients, thus reducing our revised financing bill.

#### *Non-Financial Impacts*

The non-financial impacts to WAMC vary in degree from potential to certain. One area that will certainly be affected by the impending changes will be the Joel Health Clinic. The impact on patient and staff satisfaction, access, and operations will be enormous if the Buy COA is selected. The largest non-financial concern is public relations with the Joel RSA patients. Additionally, the Joel leadership has come to rely on the support staff augmentation provided in the RSA. Particularly, the ancillary support staff has been fully integrated into the total clinic operations. However, not all of the changes affecting the clinic are negative. The positive factors for ending the RSA clinic include increased space for optimization of Joel FP Clinic services. These optimization efforts could eventually increase access and enrollment to the MTF in the Joel Health Clinic.

Other areas would see fallout from the ending of the Joel RSA Clinic, but these effects are not as well defined as the effects on Joel Health Clinic. Inpatient census could decrease, as well as outpatient specialty care. Other sections or departments might incur the additional workload formerly produced by positions vacated under the elimination of the RSA. The Emergency Department and Acute Minor Illness Clinic could become deluged with the primary care needs of the 6,000 enrollees if the contractor is unable to find suitable PCMs for them, or choose to discontinue enrollment in TRICARE Prime. The hospital's case mix for Graduate Medical Education could be unbalanced due to the high age of the Joel RSA population. And finally, the medical center's administration could find itself bogged down answering a large number of complaints from various sources.

The best arrangement possible given the current situation would be to maintain the status quo. The current arrangement provides a benefit to the MTF, the contractor, and the MHS overall. Unfortunately, status quo is not an option; therefore the least undesirable course of action must be selected.

## 5. Conclusion and Recommendations

The financial conclusion is quite clear--enrolling the Joel RSA patients to the MTF will cost the MTF far more than if they remain MCSC Prime, given the current arrangements of Revised Financing. Buying this health care leaves the command in the difficult position of informing the contractor that its 6,000 beneficiaries will no longer be seen at the Joel Health Clinic; instead, a local physician will see the patients in the network. This will most probably result in complaints from the enrollees to high profile officials such as Inspectors General, Congressmen, and the Post Commander.

Enrolling the patients to the MTF is an unattractive option. This move would probably exacerbate current issues involving capacity and access. Additionally, its enormous price tag would necessitate the reduction or elimination of services from other areas of the medical center.

By not enrolling the patients to the MTF, we will not inherit the purchased care costs for these patients, the factor that makes these patients so expensive. If we enroll the patients, they become ours to not only care for, but to also pay for their care on the network, at about \$7.5 million in 2004 adjusted for inflation.



My recommendation is to inform the contractor as soon as possible that the patients currently enrolled at Joel Resource Sharing Clinic will not be rolled over into the MTF Prime population. Our primary care panels are currently at 101% capacity (TNEX Business Plan, 2003) and cannot support the additional patients. WAMC will have to seriously cut programs to absorb the \$12-15 million bill that remains to enroll the RSA patients, even after the inpatient recapture potential is deducted from that bill. A public affairs plan with an emphasis on explaining the change is necessary to avoid negative publicity with local, and perhaps regional, media interest. The Customer Service Division and the Inspector General must be informed and prepared for those individuals that are not satisfied with this change. Additionally, in line with our strategic focus, we should move the 1,000 Active Duty Family Members assigned to the Joel RSA clinic to the top of the list for individuals awaiting enrollment at WAMC.

During the course of this project I discovered some other areas of our business practices that I recommend be changed or updated. First, our strategic plan is now over three years old. Since that strategic plan was unveiled, the world has changed significantly with the 9/11 attacks,

the Global War on Terrorism, and an increased posture on homeland security. These events greatly changed our SWOT from three years ago. WAMC also needs to conduct a trend/issue identification and evaluation that plots environmental data and speculates on the likelihood of those issues or trends having an impact on the organization strategically (Ginter et al., 2002). Also, the combination of strategies outlined by Ginter et al. should be mapped to provide a vision of the relationships of the different strategies used to address those trends and issues.

Additionally, this analysis leaves many areas begging for further research, and the development of tools for conducting this research. A sub-template that would be useful to include on the MEDCOM BCA template is pharmacy cost impact. Likewise, a tool to evaluate the impact on ancillary services would also be useful in the decision support process. Finally, another area for further study would be a quantitative measure of patient satisfaction with contract vs. hired providers and support staff. The maintenance of the patient satisfaction of the Joel RSA patients is really the most difficult facet in this decision.

The Buy COA will decrease satisfaction for those patients, at least in the short term. Still, the MCSC beneficiaries will continue to receive one of the most generous healthcare plans in the country, TRICARE Prime. They are still eligible for specialty, inpatient care, and emergency services at WAMC. The difference is that they will no longer have a primary care manager at the Joel Clinic. Many of our retirees want to be seen at Womack, but the hard fact is that we only have enrollment capacity for about 22% of them. One avenue that allowed us to see 6,000 additional retirees in our facility is no longer an option on July 1, 2004.

Appendix A

Acronym List

|        |                                      |
|--------|--------------------------------------|
| COA    | Course of action                     |
| DoD    | Department of Defense                |
| FFS    | Fee-for-Service                      |
| FTE    | Full-time equivalent                 |
| MCSC   | Managed Care Support Contractor      |
| MEDCOM | US Army Medical Command              |
| MHS    | Military Health System               |
| MTF    | Military Treatment Facility          |
| RSA    | Resource Sharing Agreement           |
| RVU    | Relative Value Unit                  |
| RWP    | Relative Weighted Procedure          |
| TMA    | TRICARE Management Activity          |
| TNEX   | TRICARE Next Generation of Contracts |



| <b>Change in Workload in the MTF</b>   |      |       |       |       |
|--|------|-------|-------|-------|
| Enter Fiscal Year (FY <u>  </u> )<br>In each column  | FY04 | FY05  | FY06  | FY07  |
| Enter the Number of Month<br>for each FY activities are expected to occur  | 3    | 12    | 12    | 9     |
| <b>Workload SHIFT Avoidance - Work that will move to the network if BCA is not put in place<br/>All MCSC 1.0 Activities &amp; For All "Non-Psych" Workload for MCSC 2.0 Activities</b> |      |       |       |       |
| Outpatient ADD RVU   |      |       |       |       |
| Outpatient NADD RVU  | 4332 | 17327 | 17327 | 12995 |
| Total CHAMPUS RVU  | 4332 | 17327 | 17327 | 12995 |
| Outpatient AD RVU  | 0    | 0     | 0     | 0     |
| Total Outpatient RVU   | 4332 | 17327 | 17327 | 12995 |
| Inpatient ADD RWP  |      |       |       |       |
| Inpatient NADD RWP   | 117  | 468   | 468   | 351   |
| Total CHAMPUS RWP  | 117  | 468   | 468   | 351   |
| Inpatient AD RWP   | 0    | 0     | 0     | 0     |
| Total Admissions   | 117  | 468   | 468   | 351   |
| <b>New Workload - Increase in MTF workload if BCA is put in place (Recapture)<br/>All MCSC 1.0 Activities &amp; For All "Non-Psych" Workload for MCSC 2.0 Activities</b>               |      |       |       |       |
| Outpatient ADD RVU   |      |       |       |       |
| Outpatient NADD RVU  | 3466 | 13862 | 13862 | 10397 |
| Total CHAMPUS RVU  | 3466 | 13862 | 13862 | 10397 |
| Outpatient AD RVU  |      |       |       |       |
| Total Outpatient RVU   | 3466 | 13862 | 13862 | 10397 |
| Inpatient ADD RWP  |      |       |       |       |
| Inpatient NADD RWP   | 76   | 302   | 302   | 227   |
| Total CHAMPUS RWP  | 76   | 302   | 302   | 227   |
| Inpatient AD RWP   |      |       |       |       |
| Total Inpatient RWP  | 76   | 302   | 302   | 227   |

Figure B2. Direct care workload sheet from Make 1 BCA

(MEDCOM BCA 5.2 template for Microsoft Excel).

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| Change in Labor Costs (O&M, MilPers)          |            |            |            |            |
|---|------------|------------|------------|------------|
| Fiscal Year (FY)                              | FY04       | FY05       | FY06       | FY07       |
| # Of Month's Personnel will be employed in FY | 3          | 12         | 12         | 9          |
| <b>Military and GS Personnel</b>              |            |            |            |            |
| Number of FTEs                                | 18.60      | 18.60      | 18.60      | 18.60      |
| Total Provider Cost                           | \$ 237,153 | \$ 948,610 | \$ 948,610 | \$ 711,458 |
|   |            |            |            |            |
|   |            |            |            |            |
| <b>Contract Personnel</b>                     |            |            |            |            |
| Number of Provider FTEs                       | 0.00       | 0.00       | 0.00       | 0.00       |
| Total Provider Cost                           | \$ -       | \$ -       | \$ -       | \$ -       |
|   |            |            |            |            |
| Number of Support Staff FTEs                  | 0.00       | 0.00       | 0.00       | 0.00       |
| Total Support Staff Cost                      | \$ -       | \$ -       | \$ -       | \$ -       |
| Change in Labor Costs                         | \$ 237,153 | \$ 948,610 | \$ 948,610 | \$ 711,458 |
| Savings or Cost                               |            |            |            |            |

Figure B3. Summary of personnel costs from Make 1 BCA  
(MEDCOM BCA 5.2 template for Microsoft Excel).

| Civilian Personnel Costs     | # of Personnel | Base Pay + Benefits (Step 5 each Grade) | Specialty Pays | Total Cost per Staff Member |
|------------------------------|----------------|---|----------------|-----------------------------|
| GS-15                        |                | \$ 127,098                              |                | \$                          |
| GS-14                        | 1              | \$ 106,049                              | \$ 27,012      | \$ 135,061                  |
| GS-13                        | 1              | \$ 91,433                               | \$ 22,859      | \$ 114,291                  |
| GS-12                        |                | \$ 76,889                               |                | \$                          |
| GS-11                        | 2.6            | \$ 64,153                               |                | \$ 166,797                  |
| GS-10                        | 1              | \$ 58,393                               |                | \$ 58,393                   |
| GS-09                        | 1              | \$ 53,020                               |                | \$ 53,020                   |
| GS-08                        |                | \$ 48,006                               |                | \$                          |
| GS-07                        | 3              | \$ 43,348                               |                | \$ 130,043                  |
| GS-06                        | 3              | \$ 39,008                               |                | \$ 117,023                  |
| GS-05                        |                | \$ 34,994                               |                | \$                          |
| GS-04                        | 2              | \$ 31,275                               |                | \$ 62,550                   |
| GS-03                        | 4              | \$ 27,859                               |                | \$ 111,435                  |
| GS-02                        |                | \$ 24,718                               |                | \$                          |
| Total Civilian Staff/Expense | 18.6           |   |                | \$ 948,610                  |

Figure B4. Detailed personnel costs from Make 1 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

| <b>Change in Marginal (Supply) Costs</b> |            |             |             |             |
|--|------------|-------------|-------------|-------------|
|  | FY04       | FY05        | FY06        | FY07        |
| *Change in Outpatient Workload           | (866)      | (3465)      | (3465)      | (2599)      |
| Marginal cost Per Outpatient Unit        | \$2.66     | \$2.66      | \$2.66      | \$2.66      |
| Total Outpatient Marginal Costs          | (\$2,304)  | (\$9,217)   | (\$9,217)   | (\$6,913)   |
| *Change in Inpatient Workload            | (42)       | (166)       | (166)       | (125)       |
| Marginal cost Per Inpatient Unit         | \$1,092.00 | \$1,092.00  | \$1,092.00  | \$1,092.00  |
| Total Inpatient Marginal Costs           | (\$45,318) | (\$181,272) | (\$181,272) | (\$135,954) |
| Total Change in Marginal Cost            | \$45,318   | \$181,272   | \$181,272   | \$135,954   |

Figure B5. Supply costs from Make 1 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).




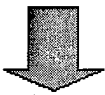
| <b>Change in Third Party Collections</b>  |  |                 |                  |                  |                  |
|---|--|-----------------|------------------|------------------|------------------|
| <b>OHI %</b><br> | <b>Collection %</b><br> | <b>Year 1</b>   | <b>Year 2</b>    | <b>Year 3</b>    | <b>Year 4</b>    |
| <b>10%</b>  | <b>70%</b>   |                 |                  |                  |                  |
| Change in MTF ADD Outpatient Visits   |  | 4,446           | 17,783           | 17,783           | 13,337           |
| Avg ADD Outpatient TPC  |  | \$74.00         | \$74.93          | \$75.86          | \$76.81          |
| (Visits) X (OHI) X (Collection %)   |  | \$328,989       | \$1,332,406      | \$1,349,061      | \$1,024,443      |
| Potential MTF TPC for ADD Care  |  | \$23,029        | \$93,268         | \$94,434         | \$71,711         |
| Change in MTF NADD Outpatient Visits  |  |                 |                  |                  |                  |
| Avg NADD Outpatient TPC   |  |                 |                  |                  |                  |
| (Visits) X (OHI) X (Collection %)   |  | \$0             | \$0              | \$0              | \$0              |
| Potential MTF TPC for NADD Care   |  | \$0             | \$0              | \$0              | \$0              |
| Change in Outpatient TPC  |  | \$23,029        | \$93,268         | \$94,434         | \$71,711         |
| Change in MTF ADD Admissions  |  | 94              | 377              | 377              | 283              |
| Avg ADD Inpatient Institutional TPC   |  | \$5,628.00      | \$5,698.95       | \$5,769.58       | \$5,841.70       |
| (Admissions) X (OHI) X (Collection %)   |  | \$530,158       | \$2,147,138      | \$2,173,978      | \$1,650,864      |
| Potential MTF TPC for ADD Care  |  | \$37,111        | \$150,300        | \$152,178        | \$115,560        |
| Change in MTF NADD Admissions   |  | 0               | 0                | 0                | 0                |
| Avg NADD Inpatient Institutional TPC  |  |                 |                  |                  |                  |
| (Admissions) X (OHI) X (Collection %)   |  | \$0             | \$0              | \$0              | \$0              |
| Potential MTF TPC for NADD Care   |  | \$0             | \$0              | \$0              | \$0              |
| Potential Change in Inpatient TPC   |  | \$37,111        | \$150,300        | \$152,178        | \$115,560        |
| <b>Total change in TPC</b>  |  | <b>\$60,140</b> | <b>\$243,568</b> | <b>\$246,613</b> | <b>\$187,272</b> |
| <b>Direct MTF Savings</b>   |  |                 |                  |                  |                  |

Figure B6. Estimated third party collections from Make 1 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

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| <b>REVISED FINANCING</b>                                      |                      |                      |                      |                      |
|---|----------------------|----------------------|----------------------|----------------------|
|   |                      |                      |                      |                      |
| <b>COST RECAPTURE SAVINGS</b>                                 | <b>FY04</b>          | <b>FY05</b>          | <b>FY06</b>          | <b>FY07</b>          |
|   |                      |                      |                      |                      |
| <b>PSC RECAPTURE OF OUTPATIENT WORKLOAD</b>                   |                      |                      |                      |                      |
| BASELINE (Current PSC) OUTPATIENT VISITS                      | 0                    | 0                    | 0                    | 0                    |
| TARGET OUTPATIENT RVU   | 3466                 | 13662                | 13662                | 10397                |
| Average Professional (Outpatient) CMAC or Outpatient PSC Cost | \$74.00              | \$74.93              | \$75.66              | \$76.81              |
| Total Outpatient Visit Cost Avoidance Savings                 | \$256,447            | \$1,038,610          | \$1,051,593          | \$798,553            |
| <b>PSC RECAPTURE OF INPATIENT WORKLOAD</b>                    |                      |                      |                      |                      |
| BASELINE (Current PSC) RWP                                    |                      |                      |                      |                      |
| TARGET (Additional Avoidance) RWP                             | 76                   | 302                  | 302                  | 227                  |
| TMA Average Inpatient Institutional Cost/ RWP                 | \$5,628.00           | \$5,908.40           | \$6,204.87           | \$6,516.11           |
| Inpatient Cost Avoidance Savings                              | \$424,914            | \$1,784,639          | \$1,873,871          | \$1,475,673          |
| Change in MTF Admissions (Target Admissions)                  |                      |                      |                      |                      |
| Negotiated Professional Fee Per Admission                     |                      |                      |                      |                      |
| Inpatient Professional Cost Avoidance Savings                 | \$0                  | \$0                  | \$0                  | \$0                  |
| Total Inpatient Cost Avoidance Savings                        | \$424,914            | \$1,784,639          | \$1,873,871          | \$1,475,673          |
| <b>Total RECAPTURE COST SAVINGS</b>                           | <b>\$681,361</b>     | <b>\$2,823,249</b>   | <b>\$2,925,464</b>   | <b>\$2,274,227</b>   |
|   |                      |                      |                      |                      |
| <b>REVISED FINANCING</b>                                      |                      |                      |                      |                      |
|   |                      |                      |                      |                      |
| <b>COST AVOIDANCE SAVINGS</b>                                 | <b>Year 1</b>        | <b>Year 2</b>        | <b>Year 3</b>        | <b>Year 4</b>        |
|   |                      |                      |                      |                      |
| <b>PSC COST AVOIDANCE FOR OUTPATIENT WORKLOAD</b>             |                      |                      |                      |                      |
| BASELINE (Current PSC) OUTPATIENT VISITS                      |                      |                      |                      |                      |
| TARGET (Additional Recapture) OUTPATIENT VISITS               |                      |                      |                      |                      |
| Average Professional (Outpatient) CMAC or Outpatient PSC Cost |                      |                      |                      |                      |
| Total Outpatient Visit Recapture Savings                      | (\$1,300,023)        | (\$5,460,097)        | (\$5,733,101)        | (\$4,514,817)        |
| <b>PSC RECAPTURE OF INPATIENT WORKLOAD</b>                    |                      |                      |                      |                      |
| BASELINE (Current PSC) ADMISSIONS                             |                      |                      |                      |                      |
| TARGET (Additional Recapture) ADMISSIONS                      |                      |                      |                      |                      |
| Average Inpatient Institutional CMAC or PSC Inpatient Cost    |                      |                      |                      |                      |
| Inpatient Institutional Recapture Savings                     | (\$410,808)          | (\$1,725,392)        | (\$1,811,661)        | (\$1,426,683)        |
| Change in MTF AD Admissions (Target Admissions)               |                      |                      |                      |                      |
| Negotiated Professional Fee Per Admission                     |                      |                      |                      |                      |
| Inpatient Professional Recapture Savings                      |                      |                      |                      |                      |
| Total Inpatient Recapture Savings                             | (\$410,808)          | (\$1,725,392)        | (\$1,811,661)        | (\$1,426,683)        |
| <b>Total COST AVOIDANCE SAVINGS</b>                           | <b>(\$1,710,831)</b> | <b>(\$7,185,488)</b> | <b>(\$7,544,763)</b> | <b>(\$5,941,500)</b> |

Figure B7. Revised finance sheet from Make 1 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

# Resource Sharing Conversion 59

## Appendix C

### BCA for Make 2 (Contract) COA

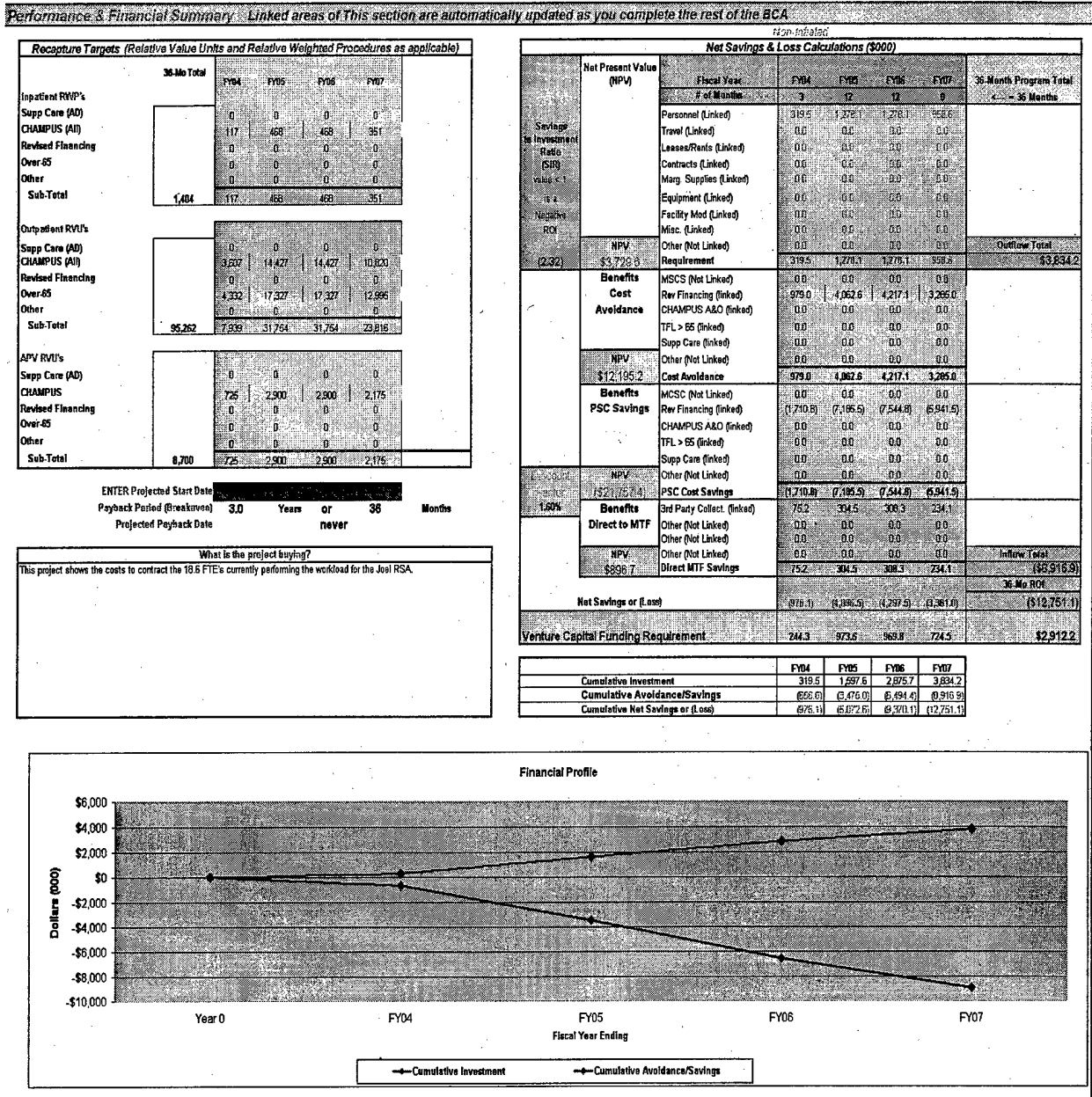


Figure C1. Summary sheet from Make 2 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

# Resource Sharing Conversion 60

| Data Entry in Yellow Boxes ONLY  |      |       |       |       |
|--|------|-------|-------|-------|
| Change in Workload in the MTF  |      |       |       |       |
| Enter Fiscal Year (FY <input type="text"/> )<br>in each column   | FY04 | FY05  | FY06  | FY07  |
| Enter the Number of Month<br>for each FY activities are expected to occur  | 3    | 12    | 12    | 9     |
| Workload SHIFT Avoidance - Work that will move to the network if BCA is not put in place<br>All MCSC 1.0 Activities & For All "Non-Psych" Workload for MCSC 2.0 Activities |      |       |       |       |
| Outpatient ADD RVU   | 714  | 2655  | 2655  | 2141  |
| Outpatient NADD RVU  | 3618 | 14472 | 14472 | 10854 |
| Total CHAMPUS RVU  | 4332 | 17327 | 17327 | 12995 |
| Outpatient AD RVU  | 0    | 0     | 0     | 0     |
| Total Outpatient Visits/SDS  | 4332 | 17327 | 17327 | 12995 |
| Inpatient ADD RWP  | 24   | 94    | 94    | 71    |
| Inpatient NADD RWP   | 94   | 374   | 374   | 281   |
| Total CHAMPUS RWP  | 117  | 468   | 468   | 351   |
| Inpatient AD RWP   | 0    | 0     | 0     | 0     |
| Total Admissions   | 117  | 468   | 468   | 351   |
| New Workload - Increase in MTF workload if BCA is put in place (Recapture)<br>All MCSC 1.0 Activities & For All "Non-Psych" Workload for MCSC 2.0 Activities               |      |       |       |       |
| Outpatient ADD RVU   | 714  | 2655  | 2655  | 2141  |
| Outpatient NADD RVU  | 3618 | 14472 | 14472 | 10854 |
| Total CHAMPUS RVU  | 4332 | 17327 | 17327 | 12995 |
| Outpatient AD RVU  |      |       |       |       |
| Total Outpatient RVU   | 4332 | 17327 | 17327 | 12995 |
| Inpatient ADD RWP  | 24   | 94    | 94    | 71    |
| Inpatient NADD RWP   | 94   | 374   | 374   | 281   |
| Total CHAMPUS RWP  | 118  | 468   | 468   | 352   |
| Inpatient AD RWP   |      |       |       |       |
| Total Inpatient RWP  | 118  | 468   | 468   | 352   |

Figure C2. Direct care workload sheet from Make 2 BCA  
(MEDCOM BCA 5.2 template for Microsoft Excel).

# Resource Sharing Conversion 61

| Change in Labor Costs (O&M, MilPers)          |              |              |              |              |  |
|---|--------------|--------------|--------------|--------------|--|
| Fiscal Year (FY)                              | Year 1       | Year 2       | Year 3       | Year 4       |  |
| # Of Month's Personnel will be employed in FY | 3            | 12           | 12           | 9            | The Num<br>entered l                           |
| <b>Military and GS Personnel</b>              |              |              |              |              |  |
| Number of Provider FTEs                       | 0.00         | 0.00         | 0.00         | 0.00         |  |
| Total Provider Cost                           | \$ -         | \$ -         | \$ -         | \$ -         |  |
| Number of Support Staff FTEs                  | 0.00         | 0.00         | 0.00         | 0.00         |  |
| Total Medical Technician Cost                 | \$ -         | \$ -         | \$ -         | \$ -         |  |
| <b>Contract Personnel</b>                     |              |              |              |              |  |
| Number of Provider FTEs                       | 12.60        | 12.60        | 12.60        | 12.60        |  |
| Total Provider Cost                           | \$ 1,039,477 | \$ 1,039,477 | \$ 1,039,477 | \$ 1,039,477 | Contract personnel an<br>verses Govt. Personne |
| Number of Support Staff FTEs                  | 6.00         | 6.00         | 6.00         | 6.00         |  |
| Total Support Staff Cost                      | \$ 238,598   | \$ 238,598   | \$ 238,598   | \$ 238,598   |  |
| Change in Labor Costs                         | \$ 319,519   | \$ 1,278,075 | \$ 1,278,075 | \$ 958,556   |  |
| <b>Savings or Cost</b>                        |              |              |              |              |  |

Figure C3. Summary of personnel costs from Make 2 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

| Contract Personnel             | # of Personnel | Base Costs | Specialty Pays | Cost per Staff Member | Cost + contract maintenance fee | Contract Maintenance | Contract Personnel Please specify Cde | # of Personnel | Base Costs | Specialty Pays | Total Cost per Staff Member | Cost + Contract Maintenance fee |
|--------------------------------|----------------|------------|----------------|-----------------------|---------------------------------|----------------------|---------------------------------------|----------------|------------|----------------|-----------------------------|---------------------------------|
| Contract Physicians            | 2              | \$ 286,999 |                | \$ 573,999            | \$ 745,197                      | 30%                  | Pharmacist                            | 1              | \$ 102,214 |                | \$ 102,214                  | 119,876.20                      |
| Contract RN                    | 2              | \$ 61,980  |                | \$ 103,980            | \$ 135,174                      |                      | Pharmacy Tech                         | 1              | \$ 34,251  |                | \$ 34,251                   | 44,656.30                       |
| Contract CAN                   | 2              | \$ 25,589  |                | \$ 61,189             | \$ 68,667                       |                      | Medical Clerks                        | 4              | \$ 14,243  |                | \$ 56,972                   | 74,063.60                       |
| Contract Physician's Assistant | 0.6            | \$ 117,269 |                | \$ 70,421             | \$ 91,548                       |                      | Contract Support Personnel            |                |            |                | \$ -                        | -                               |
| Contract Nurse Practitioner    | 1              | \$ 65,302  |                | \$ 65,302             | \$ 84,883                       |                      | Contract Support Personnel            |                |            |                | \$ -                        | -                               |
| Contract LPN                   | 2              | \$ 36,103  |                | \$ 72,216             | \$ 83,883                       |                      | Contract Support Personnel            |                |            |                | \$ -                        | -                               |
| Contract Lab Tech              | 2              | \$ 34,812  |                | \$ 69,624             | \$ 89,965                       |                      | Contract Support Personnel            |                |            |                | \$ -                        | -                               |
| Contract Rad Tech              | 1              | \$ 61,874  |                | \$ 61,874             | \$ 67,436                       |                      | Contract Support Personnel            |                |            |                | \$ -                        | -                               |
| Total Contract Staff Expense   | 12.6           |            |                | \$ 799,597            | \$ 1,039,477                    |                      | Total Contract Staff & Expense        | 6              |            |                | \$ 189,537                  | 238,598.10                      |
| Staffing Request               |                |            |                |                       |                                 |                      | Staffing Request                      |                |            |                |                             |                                 |
| Total Staff & Staff Costs      | 13             |            |                | \$ 799,597            | \$ 1,039,477                    |                      | Total Staff & Staff Costs             | 6              |            |                | \$ 189,537                  | \$ 238,598                      |

Figure C4. Detailed of personnel costs from Make 2 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).



| Change in Third Party Collections  |   |            |             |             |             |
|--|---|------------|-------------|-------------|-------------|
| OHI %<br> | Collection %<br> | Year 1     | Year 2      | Year 3      | Year 4      |
| 10%  | 70%   |            |             |             |             |
| Change in MTF ADD Outpatient Visits  |   | 5,557      | 22,229      | 22,229      | 16,672      |
| Avg ADD Outpatient TPC   |   | \$74.00    | \$74.93     | \$75.86     | \$76.81     |
| (Visits) X (OHI) X (Collection %)  |   | \$411,237  | \$1,665,508 | \$1,686,327 | \$1,280,554 |
| Potential MTF TPC for ADD Care   |   | \$28,787   | \$116,586   | \$118,043   | \$89,639    |
| Change in MTF NADD Outpatient Visits   |   |            |             |             |             |
| Avg NADD Outpatient TPC  |   |            |             |             |             |
| (Visits) X (OHI) X (Collection %)  |   | \$0        | \$0         | \$0         | \$0         |
| Potential MTF TPC for NADD Care  |   | \$0        | \$0         | \$0         | \$0         |
| Change in Outpatient TPC   |   | \$28,787   | \$116,586   | \$118,043   | \$89,639    |
| Change in MTF ADD Admissions   |   | 118        | 471         | 471         | 353         |
| Avg ADD Inpatient Institutional TPC  |   | \$5,620.00 | \$5,698.35  | \$5,769.58  | \$5,841.70  |
| (Admissions) X (OHI) X (Collection %)  |   | \$662,697  | \$2,683,923 | \$2,717,472 | \$2,063,580 |
| Potential MTF TPC for ADD Care   |   | \$46,389   | \$187,875   | \$190,223   | \$144,451   |
| Change in MTF NADD Admissions  |   | 188        | 748         | 748         | 562         |
| Avg NADD Inpatient Institutional TPC   |   |            |             |             |             |
| (Admissions) X (OHI) X (Collection %)  |   | \$0        | \$0         | \$0         | \$0         |
| Potential MTF TPC for NADD Care  |   | \$0        | \$0         | \$0         | \$0         |
| Potential Change in Inpatient TPC  |   | \$46,389   | \$187,875   | \$190,223   | \$144,451   |
| Total change in TPC  |   | \$75,175   | \$304,460   | \$308,266   | \$234,089   |
| Direct MTF Savings   |   |            |             |             |             |

Figure C5. Estimated third party collections from Make 2 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).



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| <b>REVISED FINANCING</b>                                      |                      |                      |                      |                      |
|---|----------------------|----------------------|----------------------|----------------------|
|   |                      |                      |                      |                      |
| <b>COST RECAPTURE SAVINGS</b>                                 | <b>Year 1</b>        | <b>Year 2</b>        | <b>Year 3</b>        | <b>Year 4</b>        |
|   |                      |                      |                      |                      |
| <b>PSC RECAPTURE OF OUTPATIENT WORKLOAD</b>                   |                      |                      |                      |                      |
| BASLINE (Current PSC*) OUTPATIENT VISITS                      | 0                    | 0                    | 0                    | 0                    |
| TARGET OUTPATIENT RVU   | 4,332                | 17,327               | 17,327               | 12,995               |
| Average Professional (Outpatient) CMAC or Outpatient PSC Cost | \$74.00              | \$74.93              | \$75.66              | \$76.81              |
| Total Outpatient Visit Cost Avoidance Savings                 | \$320,550            | \$1,298,225          | \$1,314,453          | \$998,163            |
| <b>PSC RECAPTURE OF INPATIENT WORKLOAD</b>                    |                      |                      |                      |                      |
| BASLINE (Current PSC) RWP                                     | 0                    | 0                    | 0                    | 0                    |
| TARGET (Additional Avoidance) RWP                             | 117                  | 468                  | 468                  | 351                  |
| TMA Average Inpatient Institutional Cost/ RWP                 | \$5,628.00           | \$5,909.40           | \$6,204.87           | \$6,515.11           |
| Inpatient Cost Avoidance Savings                              | \$658,476            | \$2,764,417          | \$2,902,638          | \$2,286,805          |
| Change in MTF RWP (Target RWP)                                | 117                  | 468                  | 468                  | 351                  |
| Negotiated Professional Fee Per Admission                     |                      |                      |                      |                      |
| Inpatient Professional Cost Avoidance Savings                 | \$0                  | \$0                  | \$0                  | \$0                  |
| Total Inpatient Cost Avoidance Savings                        | \$658,476            | \$2,764,417          | \$2,902,638          | \$2,286,805          |
| <b>Total RECAPTURE COST SAVINGS</b>                           | <b>\$979,026</b>     | <b>\$4,062,643</b>   | <b>\$4,217,091</b>   | <b>\$3,284,968</b>   |
|   |                      |                      |                      |                      |
| <b>REVISED FINANCING</b>                                      |                      |                      |                      |                      |
|   |                      |                      |                      |                      |
| <b>COST AVOIDANCE SAVINGS</b>                                 | <b>Year 1</b>        | <b>Year 2</b>        | <b>Year 3</b>        | <b>Year 4</b>        |
|   |                      |                      |                      |                      |
| <b>PSC COST AVOIDANCE FOR OUTPATIENT WORKLOAD</b>             |                      |                      |                      |                      |
| BASLINE (Current PSC*) OUTPATIENT VISITS                      |                      |                      |                      |                      |
| TARGET (Additional Recapture) OUTPATIENT VISITS               |                      |                      |                      |                      |
| Average Professional (Outpatient) CMAC or Outpatient PSC Cost |                      |                      |                      |                      |
| Total Outpatient Visit Recapture Savings                      | (\$1,300,023)        | (\$5,460,097)        | (\$5,733,101)        | (\$4,514,817)        |
| <b>PSC RECAPTURE OF INPATIENT WORKLOAD</b>                    |                      |                      |                      |                      |
| BASLINE (Current PSC) ADMISSIONS                              |                      |                      |                      |                      |
| TARGET (Additional Recapture) ADMISSIONS                      |                      |                      |                      |                      |
| Average Inpatient Institutional CMAC or PSC Inpatient Cost    |                      |                      |                      |                      |
| Inpatient Institutional Recapture Savings                     | (\$410,808)          | (\$1,725,392)        | (\$1,811,661)        | (\$1,426,683)        |
| Change in MTF AD Admissions (Target Admissions)               |                      |                      |                      |                      |
| Negotiated Professional Fee Per Admission                     |                      |                      |                      |                      |
| Inpatient Professional Recapture Savings                      |                      |                      |                      |                      |
| Total Inpatient Recapture Savings                             | (\$410,808)          | (\$1,725,392)        | (\$1,811,661)        | (\$1,426,683)        |
| <b>Total COST AVOIDANCE SAVINGS</b>                           | <b>(\$1,710,831)</b> | <b>(\$7,185,488)</b> | <b>(\$7,544,763)</b> | <b>(\$5,941,500)</b> |

Figure C6. Revised finance sheet from Make 2 BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

BCA for Buy (Network) COA



| <b>Change in Workload in the MTF</b>   |      |       |       |       |
|--|------|-------|-------|-------|
| Enter Fiscal Year (FY <u>  </u> )<br>in each column  | FY04 | FY05  | FY06  | FY07  |
| Enter the Number of Month<br>for each FY activities are expected to occur  | 3    | 12    | 12    | 9     |
| <i>Workload SHIFT- Work that will move to the network if BCA is put in place<br/>All MCSC 1.0 Activities &amp; For All "Non-Psych" Workload for MCSC 2.0 Activities</i>  |      |       |       |       |
| Outpatient ADD RVU   |      |       |       |       |
| Outpatient NADD RVU  | 4332 | 17327 | 17327 | 12995 |
| Total CHAMPUS RVU  | 4332 | 17327 | 17327 | 12995 |
| Outpatient AD RVU  | 0    | 0     | 0     | 0     |
| Total Outpatient RVU   | 4332 | 17327 | 17327 | 12995 |
| Inpatient ADD RWP  |      |       |       |       |
| Inpatient NADD RWP   | 117  | 468   | 468   | 351   |
| Total CHAMPUS RWP  | 117  | 468   | 468   | 351   |
| Inpatient AD RWP   | 0    | 0     | 0     | 0     |
| Total Admissions   | 117  | 468   | 468   | 351   |
| <i>New Workload - Increase in MTF workload if BCA is put in place (Recapture)<br/>All MCSC 1.0 Activities &amp; For All "Non-Psych" Workload for MCSC 2.0 Activities</i> |      |       |       |       |
| Outpatient ADD RVU   |      |       |       |       |
| Outpatient NADD RVU  | 0    | 0     | 0     | 0     |
| Total CHAMPUS RVU  | 0    | 0     | 0     | 0     |
| Outpatient AD RVU  |      |       |       |       |
| Total Outpatient RVU   | 0    | 0     | 0     | 0     |
| Inpatient ADD RWP  |      |       |       |       |
| Inpatient NADD RWP   | 0    | 0     | 0     | 0     |
| Total CHAMPUS RWP  | 0    | 0     | 0     | 0     |
| Inpatient AD RWP   |      |       |       |       |
| Total Inpatient RWP  | 0    | 0     | 0     | 0     |

Figure D2. Direct care workload sheet from Buy BCA (MEDCOM  
BCA 5.2 template for Microsoft Excel).

| <b>Change in Marginal (Supply) Costs</b> |               |               |               |               |
|--|---------------|---------------|---------------|---------------|
|  | <b>Year 1</b> | <b>Year 2</b> | <b>Year 3</b> | <b>Year 4</b> |
| *Change in Outpatient Workload           | 4332          | 17327         | 17327         | 12995         |
| Marginal cost Per Outpatient Unit        | \$2.66        | \$2.66        | \$2.66        | \$2.66        |
| Total Outpatient Marginal Costs          | \$11,522      | \$46,090      | \$46,090      | \$34,567      |
| *Change in Inpatient Workload            | 117           | 468           | 468           | 351           |
| Marginal cost Per Inpatient Unit         | \$1,092.00    | \$1,092.00    | \$1,092.00    | \$1,092.00    |
| Total Inpatient Marginal Costs           | \$127,764     | \$511,056     | \$511,056     | \$383,292     |
| Total Change in Marginal Cost            | \$139,286     | \$557,146     | \$557,146     | \$417,859     |

Figure D3. Supply costs from Buy BCA (MEDCOM BCA 5.2 template for Microsoft Excel).



| <b>Change in Third Party Collections</b>  |  |                 |                  |                  |                  |
|---|--|-----------------|------------------|------------------|------------------|
| <b>OHI %</b><br> | <b>Collection %</b><br> | <b>FY04</b>     | <b>FY05</b>      | <b>FY06</b>      | <b>FY07</b>      |
| <b>10%</b>  | <b>70%</b>   |                 |                  |                  |                  |
| Change in MTF ADD Outpatient Visits   |  | 5,557           | 22,229           | 22,229           | 16,672           |
| Avg ADD Outpatient TPC  |  | \$74.00         | \$74.93          | \$75.86          | \$76.81          |
| (Visits) X (OHI) X (Collection %)   |  | \$411,237       | \$1,665,508      | \$1,686,327      | \$1,280,554      |
| Potential MTF TPC for ADD Care  |  | \$28,787        | \$116,586        | \$118,043        | \$89,639         |
| Change in MTF NADD Outpatient Visits  |  | 4332            | 17327            | 17327            | 12995            |
| Avg NADD Outpatient TPC   |  |                 |                  |                  |                  |
| (Visits) X (OHI) X (Collection %)   |  | \$0             | \$0              | \$0              | \$0              |
| Potential MTF TPC for NADD Care   |  | \$0             | \$0              | \$0              | \$0              |
| Change in Outpatient TPC  |  | \$28,787        | \$116,586        | \$118,043        | \$89,639         |
| Change in MTF ADD Admissions  |  | 118             | 471              | 471              | 353              |
| Avg ADD Inpatient Institutional TPC   |  | \$5,628.00      | \$5,696.35       | \$5,769.58       | \$5,841.70       |
| (Admissions) X (OHI) X (Collection %)   |  | \$662,697       | \$2,683,923      | \$2,717,472      | \$2,063,580      |
| Potential MTF TPC for ADD Care  |  | \$46,389        | \$187,875        | \$190,223        | \$144,451        |
| Change in MTF NADD Admissions   |  | 188             | 748              | 748              | 562              |
| Avg NADD Inpatient Institutional TPC  |  |                 |                  |                  |                  |
| (Admissions) X (OHI) X (Collection %)   |  | \$0             | \$0              | \$0              | \$0              |
| Potential MTF TPC for NADD Care   |  | \$0             | \$0              | \$0              | \$0              |
| Potential Change in Inpatient TPC   |  | \$46,389        | \$187,875        | \$190,223        | \$144,451        |
| <b>Total change in TPC</b>  |  | <b>\$75,175</b> | <b>\$304,460</b> | <b>\$308,266</b> | <b>\$234,089</b> |

Figure D4. Estimated third party collections from Buy BCA  
(MEDCOM BCA 5.2 template for Microsoft Excel).

## Resource Sharing Conversion 68

| <b>REVISED FINANCING</b>                                      |                    |                      |                      |                      |
|---|--------------------|----------------------|----------------------|----------------------|
| <b>COST RECAPTURE SAVINGS</b>                                 | <b>Year 1</b>      | <b>Year 2</b>        | <b>Year 3</b>        | <b>Year 4</b>        |
| <b>PSC RECAPTURE OF OUTPATIENT WORKLOAD</b>                   |                    |                      |                      |                      |
| BASELINE (Current PSC) OUTPATIENT VISITS                      | 0                  | 0                    | 0                    | 0                    |
| TARGET OUTPATIENT RVU   | -4,332             | -17,327              | -17,327              | -12,995              |
| Average Professional (Outpatient) CMAC or Outpatient PSC Cost | \$74.00            | \$74.93              | \$75.86              | \$76.81              |
| Total Outpatient Visit Cost Avoidance Savings                 | (\$320,550)        | (\$1,298,225)        | (\$1,314,453)        | (\$998,163)          |
| <b>PSC RECAPTURE OF INPATIENT WORKLOAD</b>                    |                    |                      |                      |                      |
| BASELINE (Current PSC) RWP                                    | 0                  | 0                    | 0                    | 0                    |
| TARGET (Additional Avoidance) RWP                             | (117)              | (458)                | (458)                | (351)                |
| TMA Average Inpatient Institutional Cost/ RWP                 | \$5,628.00         | \$5,909.40           | \$6,204.87           | \$6,515.11           |
| Inpatient Cost Avoidance Savings                              | (\$658,476)        | (\$2,764,417)        | (\$2,902,638)        | (\$2,286,805)        |
| Change in MTF Admissions (Target Admissions)                  | (117)              | (458)                | (458)                | (351)                |
| Negotiated Professional Fee Per Admission                     |                    |                      |                      |                      |
| Inpatient Professional Cost Avoidance Savings                 | \$0                | \$0                  | \$0                  | \$0                  |
| Total Inpatient Cost Avoidance Savings                        | (\$658,476)        | (\$2,764,417)        | (\$2,902,638)        | (\$2,286,805)        |
| <b>Total RECAPTURE COST SAVINGS</b>                           | <b>(\$979,026)</b> | <b>(\$4,062,643)</b> | <b>(\$4,217,091)</b> | <b>(\$3,284,968)</b> |
| <b>REVISED FINANCING</b>                                      |                    |                      |                      |                      |
| <b>COST AVOIDANCE SAVINGS</b>                                 | <b>Year 1</b>      | <b>Year 2</b>        | <b>Year 3</b>        | <b>Year 4</b>        |
| <b>PSC COST AVOIDANCE FOR OUTPATIENT WORKLOAD</b>             |                    |                      |                      |                      |
| BASELINE (Current PSC) OUTPATIENT VISITS                      |                    |                      |                      |                      |
| TARGET (Additional Recapture) OUTPATIENT VISITS               |                    |                      |                      |                      |
| Average Professional (Outpatient) CMAC or Outpatient PSC Cost |                    |                      |                      |                      |
| Total Outpatient Visit Recapture Savings                      | \$1,300,023        | \$5,460,097          | \$5,733,101          | \$4,514,817          |
| <b>PSC RECAPTURE OF INPATIENT WORKLOAD</b>                    |                    |                      |                      |                      |
| BASELINE (Current PSC) ADMISSIONS                             |                    |                      |                      |                      |
| TARGET (Additional Recapture) ADMISSIONS                      |                    |                      |                      |                      |
| Average Inpatient Institutional CMAC or PSC Inpatient Cost    |                    |                      |                      |                      |
| Inpatient Institutional Recapture Savings                     | \$410,808          | \$1,725,392          | \$1,811,661          | \$1,426,683          |
| Change in MTF AD Admissions (Target Admissions)               |                    |                      |                      |                      |
| Negotiated Professional Fee Per Admission                     |                    |                      |                      |                      |
| Inpatient Professional Recapture Savings                      |                    |                      |                      |                      |
| Total Inpatient Recapture Savings                             | \$410,808          | \$1,725,392          | \$1,811,661          | \$1,426,683          |
| <b>Total COST AVOIDANCE SAVINGS</b>                           | <b>\$1,710,831</b> | <b>\$7,185,488</b>   | <b>\$7,544,763</b>   | <b>\$5,941,500</b>   |

Figure D5. Revised finance sheet from Buy BCA (MEDCOM BCA 5.2 template for Microsoft Excel).

## Appendix E

## Results Summary

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| <b>Course of Action Make 1</b> (Create health care supply, by hiring. Enroll Joel RSA patients to MTF.)  |
| <b>Advantages</b>  |
| <ol style="list-style-type: none"> <li>1. Keeps current RSA patients enrolled to Joel, maintaining customer satisfaction</li> <li>2. Greater command and control of operations using GS employees</li> <li>3. Greater control of the HR function using GS employees</li> <li>4. Stable, permanent positions</li> </ol>         |
| <b>Disadvantages</b>   |
| <ol style="list-style-type: none"> <li>1. \$15.2M price tag over first three years</li> <li>2. Panel size may decrease due to lack of a FFS incentive</li> <li>3. Slow hiring/replacement practices in the DoD</li> </ol>  |
| <b>Recommendation:</b> Least desirable course of action due to exuberant costs. Since this is an unfunded project, the funds to pay for revised financing would have to come from other WAMC services.   |
| <b>Course of Action Make 2</b> (Create health care supply, by contracting. Enroll Joel RSA Providers to MTF.)  |
| <b>Advantages</b>  |
| <ol style="list-style-type: none"> <li>1. Keeps current RSA patients enrolled to Joel, maintaining customer satisfaction</li> <li>2. Keep FFS incentive thereby maintaining large panel size</li> <li>3. Flexibility in removal of poorly performing staff</li> <li>4. Greater speed in bringing employees on board</li> </ol> |
| <b>Disadvantages</b>   |
| <ol style="list-style-type: none"> <li>1. \$12.3M price tag over three years due to RF network costs</li> <li>2. Contractor maintains control of the majority of HR functions</li> <li>3. Commander has less control of contract employees</li> </ol>  |
| <b>Recommendation:</b> Undesirable due to high costs and reasons listed for Make 1. Still, this is the better of the "Make" courses of action.   |

## Appendix E

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| <b>Course of Action Buy</b> (Enroll patients with PCM on the network.)   |
| <b>Advantages</b>  |
| <ol style="list-style-type: none"> <li>1. \$8M net cost avoidance and lower marginal costs- all costs fall on the contractor, including RF Bill</li> <li>2. Releases government clinic space to optimize Joel Family Practice Clinic or Soldier Readiness Center mission</li> <li>3. Potentially can increase access for the 120,000 MTF enrollees</li> </ol>          |
| <b>Disadvantages</b>   |
| <ol style="list-style-type: none"> <li>1. Public relations with retired beneficiaries will suffer</li> <li>2. Human factor of releasing contract employees that have become an integral part of the Joel Clinic</li> <li>3. Potential loss of inpatient and specialty business to the MTF</li> <li>4. Little control of inpatient admissions in the network</li> </ol> |
| <b>Recommendation:</b> Most desirable course of action: prevents budget cuts in other areas of the medical center as well as potentially increasing access for MTF Prime.  |

Figure E1. Results comparison matrix.

References

- Army Medical Department. (2003). *Army Medical Department market management plan of instruction*. Paper presented at the TRICARE Commander's Conference 14 July 2003, Bethesda, MD.
- Beard, B. (2003). [Resource source sharing conversions]. Unpublished raw data.
- Boham, R. (2000). *Make vs. buy: An analysis of the Victory Clinic and the primary care empanelment model at the Martin Army Community Hospital*. Unpublished Graduate Management Project. Baylor University, Waco, Texas.
- Bowman, J. (2002, 1 August.). *Providing decision support for a world-class Military Health System*. [Slide presentation]. Presented at US Army-Baylor University Program in Health Care Administration August 1, 2002.
- Center for the Evaluative Clinical Sciences at Dartmouth Medical School. (1999). *Dartmouth atlas of health care*. Retrieved 15 January from <http://www.dartmouthatlas.org/atlaslinks/99atlas.php>.
- Davis, J. (Ed.). (2000). *Managed care systems and emerging infections: Opportunities for strengthening surveillance, research, and prevention*. Washington, DC: National Academy Press.

- Donahoo, J. (2003, 2 September.). *Making a strong program stronger*. [Slide presentation]. Presented at Command Leadership Program September 24, 2003, Fort Bragg, NC.
- Eden, S. (2002). *Optimizing the MTF through resource sharing*. [Slide presentation] Presented at Baylor TFMEP, November 2002.
- Eden, S. (2002). *TNEX- TRICARE next generation of contracts*. [Slide presentation]. Presented at Baylor TFMEP, November 2002.
- Finkler, S. and Ward, D. (1999). *Essentials of cost accounting for health care organizations*. (2nd ed.). Gaithersburg, MD: Aspen Publishers.
- Fottler, M. (2002). *Strategic human resources management*. In Fried, B. & Johnson J. (Eds.), *Human resources in healthcare* (pp.185-196). Chicago: Health Administration Press.
- Gapenski, L. (2001). *Understanding healthcare financial management*. (3rd ed.). Chicago: Health Administration Press
- Ginter, P., Swayne, L., Duncan, W. (2002). *Strategic management of health care organizations*. (3rd ed.). Oxford: Blackwell Publishers.



Hallowell, B. (2003) Tips on transforming on organization.

*Healthcare Financial Management*. 57(6): 64-65.

Maloy, M. (2003). [FY 2002 inpatient dispositions performed on the MCSC reliant beneficiaries enrolled at the Joel Resource Sharing Clinic, Ft Bragg, NC]. Unpublished raw data.

Maloy, M. (2003). [FY 2002 outpatient visits performed on the MCSC reliant beneficiaries enrolled at the Joel Resource Sharing Clinic, Ft Bragg, NC]. Unpublished Raw Data.

McGee, W. & Hudak, R. (1995). Reengineering medical treatment facilities for TRICARE: The medical group practice model. *Military Medicine*. 160, 235-239.

Pacchiana, S. (1997). *Staffing structure for the Joel Health/ Dental Clinic*. Unpublished graduate management project, Baylor University, Waco, Texas.

Randolph, L. (2001, October 25). *TRICARE next generation contracts: Proposed concepts*. [Slide presentation]. Retrieved August 21, 2003 from TRICARE Next Generation of Contracts Web Site, <http://www.tricare.osd.mil/pmo/t-nex/t-nex>.

Schmidt, M. (2002) *The business case guide* (2nd ed.). Boston: Solution Matrix.

- Sorenson R. & Grytten, J. (2003). Service production and contract choice in primary care physician services. *Health Policy*, 66, 73-29.
- Rubin, B. (2003, November). *Resource sharing agreements: briefing for MHS Leadership Conference*. Paper presented at the MHS Leadership Conference, Alexandria, VA.
- Van Amerongen, D. (2002) Physician Compensation. In Fried, B. & Johnson J. (Eds.), *Human resources in healthcare* (pp.185-196). Chicago: Health Administration Press.
- Wolosin, R. (2003, August). *Largest study of patient satisfaction ever conducted*. (Available from the Press Ganey Associates, 404 Columbia Place, South Bend, IN 46601)
- Womack Army Medical Center. (2003). *WAMC TNEX FY03-05 business plan*. Fort Bragg, NC.
- Womack Army Medical Center. (2001). *Womack Army Medical Center strategic plan*. Fort Bragg, NC.